ABSTRACT

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INDICATORS OF ETIOLOGY OF EATING DISORDERS AMONG ADULT MALES

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The purpose of this study was to identify possible factors that may cause the development of eating disorders. A exploratory design, using males without eating disorders from the Metro-Atlanta Area. The data were collected by completion of self-report scales designed to measure feminine and masculine traits, dieting and eating patterns, and body dissatisfaction. The instruments utilized were the Bem Sex-Role Inventory and the Eating Disorders Inventory. The data were analyzed using descriptive statistics and are reported in terms of frequency distribution and percentages. The findings of this study indicate that males may develop eating disorders based on their dieting and eating patterns and poor body image concepts. There was no significant difference between heterosexuals and homosexual males.

INDICATORS OF ETIOLOGY OF EATING DISORDERS AMONG ADULT MALES

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I thank God for the strength and courage to continue along the path that He has shown me. I would also like to express my gratitude to my family, friends and the faculty of Clark Atlanta University School of Social Work for their continued support and works of encouragement.

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CHAPTER ONE

INTRODUCTION

Eating disorders in males makes up a fascinating, sometimes neglected area of clinical and research interest, of greater importance in the current day when pressures on males to change in weight and shape are increasing.[1] Little has been written in the social work literature to examine the psychosocial factors that contributes to anorexia nervosa and bulimia nervosa among males. This is an extremely important clinical issue which can help enlighten and direct social work practice with this population. This phenomenon has only recently begun to find itself into the literature. Knowledge of how this disorder manifest itself among males can help the social worker to organize, understand, and then treat the anorexic or bulimic male.

Over the years, in discussions, institutes, conferences, workshops, and other professional meetings, a slow but certain array of information regarding psychosocial factors that contributes to anorexia nervosa and bulimia nervosa among females has emerged. Experts state that too many women and men spend their lives trying to mold themselves into a fantasy image of physical perfection. "Even though some experts see a decline in social pressure to be tall and thin, therapists and nutrition counselors say body image continues to be a key issue.[2] According to Bulik[3], bulimia is more prevalent among females than among males because it may represent an alternative expression of addiction among females.

In the last two to three decades, the prevalence of eating disorders among males has become a source of serious health and social problems. The increase of males

with a disorder predominately associated with females has drawn concern from the medical, psychiatric, and psychological disciplines. The question stands, where is the social work profession today with respect to its basic beliefs about anorexia nervosa and bulimia nervosa among males. Eating disorders "are a signal that the environment is not meeting the individuals needs."[4]

The social work profession needs to examine the factors that influence and contribute to eating disorders in males. Eating disorders are emotionally based and the social work profession needs to have an understanding of the general issues and features of eating disorders and how they function. The emotional, behavioral, psychological and physical symptoms that are associated with these disorders are more than problems of dysfunctional eating behaviors. They are dictated by and reinforced by the culture in which people live and the environment in which people function as individual units of society.

STATEMENT OF THE PROBLEM

It would be difficult to be in the field of social work and not be aware of the increasing incidence of anorexia nervosa and bulimia nervosa as an increasing health problem among males. The social work practitioner must be conversant with the ramifications of anorexia nervosa and bulimia nervosa for males.

Males today are faced with new challenges in nearly every area of their lives. Their self-concept, body image, and sexual orientation have undergone profound changes, and they are confronted with new problems, concerns, and anxieties.

Males who have eating disorders have become an increasing concern of practitioners. Many males with these life threatening illnesses are unaware of the gravity of their illness. Many males come for treatment because they are experiencing stress and various other symptoms. Certainly many individuals with eating disorders, especially anorexia nervosa and bulimia nervosa, manifest substance. A substance abuse diagnosis is also made in the first degree relatives of such individuals.

SIGNIFICANCE OF THE STUDY

The rarity of literature on eating disorders among the male population is minute compared to the literature that has been written about female eating disorders. Surprisingly, even less has been determined to be emotionally based. The primary reason for the lack of literature is the fact that eating disorders have been predominately associated with females; also the fact that usually only females seek treatment and males who are in treatment have been referred by a doctor. Most males in treatment tend to be in their late twenties to mid-thirties, obese, homosexual and/or bisexual. However, there is an abundance of literature comparing males with eating disorders to females with eating disorders.

The purpose of this study was to evaluate anorexia nervosa and bulimia nervosa among males. The study will view a variety of psychological and physical problems that arise from a constellation of factors and circumstances. The social work

profession can be quite instrumental in helping anorexic and bulimic males, as well as females. The etiology of anorexia nervosa and bulimia nervosa among males remains an issue of speculation.

ENDNOTES

[1]Arnold Andersen, "Eating Disorders in Males: Critical Questions", In Controlling Eating Disorders with Facts, Advice, and Resources. 21.

[2]"Quest for perfection still an obsession," Charlotte Observer.

[3]C.M. Bulik, "Drug and Alcohol Abuse by Bulimic Women and their Families," American Journal of Psychiatry, 144, 1987, 1604-1606.

[4]K.L. Nagel and Karen Jones, "Sociological Factors In The Development Of Eating Disorders," Adolescence, Vol.27, No. 105, Spring 1992, 108.

CHAPTER TWO

REVIEW OF THE LITERATURE

This review of the literature will give a historical overview of eating disorders and seek to examine 1) the conceptualization of bulimic and anorexic symptoms, 2) relevant characteristics of bulimia and anorexia in males, 3) sexual orientation and body image as etiology of eating disorders and 4) limitations of the literature presented.

Historical Overview

The first recorded medical case of anorexia nervosa was of a 16 year old male who did not have any other physical aliments to explain his emaciation. Dr. Richard Morton (1689) at the time named the illness "nervous consumption". It was Sir William Gull (1873) who coined the term anorexia nervosa. He also stated that although anorexia was found most frequently in females it could be found in males as well.[1] Evidence of anorexia or self-starvation in males continued to be published in the 17th, 18th and 19th centuries.[2] However, as time progressed and society entered the 20th century many clinician and theorists found anorexia to be a disorder of females. The diagnosis of anorexia in boys and men was over looked for the following reasons: 1) most clinicians saw too few cases of the disorder in females, much less males, to be familiar enough with it to make an accurate diagnosis, 2) theoreticians who believed that it was necessary to find the psychodynamic motif of "fear of oral impregnation" 3), and the criterion of amenorrhea (abnormal absence of

menstruation).[3] Andersen opposes this position by stating that Dr. Morton's historical publication of anorexia in a male and the outcome of treatment in the male was satisfactory are two important points that should be discussed in any consideration of eating disorders of males.[4] Researchers Ryle, Bruch, and Kay and Leigh also defend this position.[5]

According to Palazzoli, the medical and psychological literature on anorexia nervosa is enormous. She divides the history into an initial period that provides identification of the disease and first case histories in the 17th century; a second phase in the 19th century, which describes its essential symptomatology; and a third phase in the early 20th century, in which anorexia nervosa was defined as pituitary cachexia and classified as an endocrine deficiency; and a fourth contemporary phase characterized by existential, phenomenologic, and psychoanalytic efforts to understand the psychological ideology of the illness.[6]

Casper notes that the current literature on bulimia is predominately descriptive. Casper also notes that few reports of overeating in relation to anorexia nervosa have appeared between 1890 and 1940. She also notes that, as a symptom, overeating has been described clinically since the turn of the century and has been related to diabetes mellitus, malaria, and separation anxiety.[7] The first well documented description of the bulimia syndrome occurring in conjunction with anorexia nervosa in 1944. Russell coined the term bulimia nervosa to distinguish the pattern of overeating followed by vomiting or purgative use from that of severe weight loss produced by

starvation as seen in anorexia nervosa.[8] Recent reports indicate that approximately one half of anorexic patients also exhibit bulimia.

During the 1950s - 70s not much was reported about eating disorders in the literature, but Bruch kept an interest alive in the disorder during these decades. She did this because of the trend to diagnosis virtually all anorexic patients as schizophrenic. She recognized this entity in males, noting that true primary anorexia occurred in five of nine males treated by her for this disorder.[9] Up until this time all males with eating disorders had a primary diagnosis of some other mental illness. The eating disorder was considered to be secondary to their pre-existing illness. In the 1960s other researchers noted the occurrence of anorexia in males, and interest has been increasing every since. As a result of this increasing interest bulimia nervosa was defined as a clinical disorder in the late 1970s. The study of bulimia in males is still in its early stages. Into the 1970s anorexia and bulimia were believed to occur only in atypical forms in males, or in the presence of overt gender-identity disturbance.[10] All males with eating disorders were considered to be homosexual or confused about their gender-identity with regards to their sexuality. Weight conditions and body image have plagued men for centuries, but their plight has been eclipsed by societal attention to women with weight disorders.[11] Notable men in history are recorded as having eating disorders. Franz Kafka, author of The Hunger Artis and The Metamorphosis is seen as having suffered from atypical anorexia. William Howard Taft, President of the United States was excessively fat and very troubled by his failed attempts to lose weight. The book In Never Satisfied

documents in great detail the obsessive weighting rituals of men in the 1700s.[12] During the 1980s, the eating disorders of pop singer Elton John and Chicago Bears' William "Refrigerator" Perry were highly publicized in an effort to reduce the stigmatism for men and to increase awareness of the disorder in men. Men may assume they are not vulnerable because of the prevailing view in the media that the disorder only occurs in females.[13] This widely held belief supports the findings of undiagnosed cases of anorexia in males.[14] Anorexia in males remains underdiagnosed because they may be too embarrassed to report their symptoms to physicians or psychologists.[15] Traditionally males have been taught through American culture that they are to be strong, silent and not to complain. This is the reason why males do not complain about any physical pain and have to be pushed by female relatives to see a doctor. Thus, males would rather die than see someone about an emotional problem because only females show their emotions. Patrick Engelmann and Tom Lukan stated that the fact that eating disorders are considered feminine prolonged their seeking help.[16]

Conceptualization of Bulimic and Anorexic Symptoms

Eating disorders have afflicted millions of people, threatening their health and sometimes their lives. Bulimics often are able to hide their problem for years because they eat normally around other people and binge and purge in private.[17] They also maintain normal body weight while the disorder destroys their body. Anorexics can also hide their disorder until they become seriously underweight and malnourished.[18]

"Eating disorders are psychological rather than physical ailments.[19] Bulimics typically use food to cope with stress and anxiety. Studies indicate that 20 to 30 percent of bulimics are chronically depressed. Male and female bulimics typically have many other underlying clinical symptoms that are manifested through their eating disorder. Garfinkel states that bulimics are more outgoing and sexually active; sex is rarely enjoyable for them and they often feel used in sexual relationships.[20] While anorexics tend to be perfectionists who are self-critical, socially withdrawn and preoccupied with losing weight.[21] Bruch has found that anorexics show little interest in heterosexual relationships and are resistant to learning about sexuality.[22] Therefore, they develop maladaptive coping systems or defense mechanisms to deal with these fears about sexuality. This is especially true during adolescents. "In many cases the onset of the illness occurs during adolescents when they are experiencing fears of growing up or separation from their families. New or threatened sexual experiences, new environmental demands, disruptions of family balance, threats on self-esteem, or coincidental illness may trigger the abnormal behavioral adaptation.[23]

Some studies indicate that as many as half of the people who suffer from eating disorders have been sexually abused as young children. Many also come from families in which one or both of the parents are alcoholic, abusive or has had an eating disorder. Although most people who suffer from eating disorders are white (adolescent to mid-twenties) females from middle-class families, eating disorders are also increasing in males, African-Americans and other minorities. Certain groups of young males seem to be especially high risk. They include males who place an

excessive amount of emphasis on slimness, body image or making a certain weight, such as models, dancers and long-distance runners.[24]

Data from several studies have implicated that the chief or key risk factor in the development of eating disorders "may be dieting itself." It is believed that the major difference between males and females with regard to the etiology of eating disorder is not dissatisfaction with body weight or image but rather actual behaviors related to diet and exercise.[25] While attempting to gain control over their bodies, males exercise and females diet. In agreement with several studies it has been found that gender is a significant predictor of perceived overweight and dissatisfaction with body shape.[26]

The perceived differences in male and female behavior with regard to eating and dieting behavior has been equated to personality. Thoma emphasizes the abnormal psychic development of the anorexic or bulimic and stresses that only seldom can a psychological trauma be elicited before the onset of the illness, as opposed to characterizing the family environment as pathogenic.[27] Most people believe that eating disorders are the result of being sexually abused or raped. This is very rarely true. Eating disorders are the result of control issues during infancy, childhood and adolescent psychic development. Bruch states that anorexics are subject to conflicts over initiative and autonomy, are unprepared to assume the responsibilities and independence encountered during adolescents after a childhood of obedience and dependence.[28] As a result eating disorders may develop as a concurrent occurrence of dieting behavior and a significant life stress that overwhelms the individuals coping

skills e.g. divorce, job loss or increased job responsibility and children going off to college.[29]

The DSM III R criteria for anorexia nervosa requires:

A. Refusal to maintain body weight over a minimal normal weight for age and height, e.g., weight loss leading to maintenance of body weight 15% below that expected.

B. Intense fear of gaining weight or becoming fat, even though underweight

C. Disturbance in the way in which one's body weight, size, or shape is experienced, e.g., the person claims to "feel fat" even when emaciated, believes that one area of the body is too fat even when obviously underweight.[30]

The DSM III R criteria for bulimia nervosa requires:

A. Recurrent episodes of binge eating.

B. A feeling of lack of control over eating behavior during the eating binges.

C. The person regularly engages in either self-induced vomiting, use of laxatives or diuretics, strict dieting or fasting, or vigorous exercise in order to prevent weight gain.

D. A minimum average of two binge eating episodes a week for at least three months.

E. Persistent overconcern with body shape and weight.[31]

Relevant Characteristics of Bulimic and Anorexic Symptoms in Males

The literature is abundant with information about the etiology and development of eating disorders in females. However, there is no conclusive data as to the causal relationship of symptoms in the eating disordered male. Furthermore most symptoms in the male are always considered in comparison to the female. The limited research into the symptoms of the eating disordered male have brought to light some relevant characteristics that are distinguishable only among them.

Theorists have suggested that personality factors may play a more important role in the development of eating disorders in males than females.[32] What factors in development might explain why eating disordered males develop such a passive dependent approach to life and why controlling their body becomes their means to gaining control? How does psychosocial development interact with body image to cause males to be vulnerable to concerns about their body?[33] This can be seen in the stereotype of the "strong silent type" such as the characters portrayed by Richard Roundtree, Jim Brown, Denzel Washington, John Wayne, Sean Connery, Mel Gibson and Wesley Snipes. These men portrayed a strong physical presence which gave them points for masculinity.

A personality profile of eating disordered males tends to show dependent, avoidant and passive-aggressive personality styles, and to have experienced negative reactions to their bodies from their peers while growing up.[34] Dependent personalities are distinguished from other pathological patterns by their marked need

for social approval and affection and by their willingness to live in accord with the desires of others.[35] The avoidant personality actively detaches from others due to their over-sensitivity to social stimuli. They are hyperactive to the moods and feelings of others, especially feelings of rejection and humiliation.[36]

The passive-aggressive personality suffers from contradictory family messages. There is a tendency to be labile in affect, which is a "mirror" of the inconsistent behaviors and reinforcements they were exposed to while growing up. They also have deeply rooted feelings of ambivalence about themselves and others.[37] Kearney Cooke and Steichen-Asch, from their research, speculate that males with these personality traits had a parent(s) who discouraged independence and possibly set up barriers to keep their children from gaining autonomy.[38] Thus, in a society that perpetuates physical fitness, having a lean muscular body could provide an opportunity for these males to attain an identity. These males also tend to be closer to their mothers than to their fathers.

Sours hypothesized that increased identification with the mother might play a role in the eating disordered males need to rid the body of all fat. Boys who later develop eating disorders do not conform to the cultural expectations of masculinity; they tend to be more dependent, passive and nonathletic, traits which may lead to feelings of isolation and disparagement of the body.[39] This disparagement leads to "attempts to change their bodies to gain a sense of power and control.[40] Males who are seen as having feminine traits are seen as not having power or authority. Bruch states that the concern with food and exercise is nothing more than the last phase in

the maldevelopment of their personality "to make themselves over or to be perfect in the sight of others.[41]

The reason that these feelings in males have remained a secret for so long is the belief that the American male has been satisfied with their body image.[42] American culture has taught us that only women need to be beautiful and to be put on a pedestal. Men who think this way are weak and worthless. Further perpetuating this myth was the emphasis that weight standard and a thin muscular body ideal was restricted to select male athletes or homosexual males.[43] However, there is now data to indicate that males too experience body dissatisfaction.[44] The males dissatisfaction with his body is further enhanced by the society and culture we live in.

The culture we live in bombards us with images of an ideal body build for males and females.[45] What is the meaning of the ideal male body shape? Does the presentation of a powerful body and the "rugged" fashion trend make a statement about the males longing for a time when "men" were in charge? Do males feel threatened by the women's movement and need to flex their muscles in an attempt to be sexually dominant as their traditional masculine roles disappear?[46] Yet, through peers and the media young males are confronted daily with a definition of manhood which is distorted, dysfunctional and potentially destructive. This popular ideal of the male body overemphasizes physical strength, force and athletic skills. Yet, where else can young males turn to understand their emerging manhood?[47]

During the 1980s as women became a formidable force in the workplace and took on more character traits that were considered to be masculine, they had to integrate

the qualities that allowed them to be a homemaker and a competent adversary in the work place. However, men did not seem to do this as well. As more men became "Mr. Moms" it was difficult for them to integrate masculine and feminine traits into their lives.

Franzoi and Shields found that body image is a multidimensional construct which differs for males and females. For the male this dimension is associated with upper body strength, physical attraction and physical condition.[48] Lipman states that the early American value system stressed the attributes of physical prowess for males. This made sense then because it was necessary to function in frontier and rural society. Therefore, it is puzzling that many males still prefer the full-chested, thin-waisted body shape as the look of strength and agility.[49] This ideal can be seen on many billboards today as the "The Marlboro Man". An article in the February 1, 1988 issue of Newsweek entitled, "Sylan Chic: The Marketing of Masculinity", states that fashion and society are cashing in on the nostalgia of a time when "men were men".[50]

The media portray males as concerned with physical fitness. DiDomenico and Andersen found that magazines targeted at males contained shape articles and advertisements.[51] A 1988 poll conducted by Psychology Today found that "little boys are taught to be proud of themselves because they are strong and athletic . . ."[52] A pitfall to this belief is that athletic activity may become obsessive and detrimental to the physical and mental well-being of males. This has been noted in studies by Burckes-Miller & Black; Rowley & Yates; and Leehey & Shisslak.[53]

Psychologists Craig Johnson, Co-director of the Eating Disorders Program at Northwestern University thinks that males fall prey to eating disorders largely because of their chosen occupations.[54] These occupational hazards are jockeys, wrestlers, swimmers, models, dancers, flight attendants, etc. The question as to whether males with maladaptive eating behaviors and body image distortions seek out particular occupations or whether these occupational choices may cause eating disorders remains unanswered.[55]

Other issues that are relevant to male bulimics and anorexics are 1) their lack of initiative to seek psychiatric help and when they do it is under considerable family pressure.[56] 2) Males tend to be more resistant to treatment than their female counterparts.[57] 3) The males cessation of semen production may be analogous to amenorrhea in females[58] and 4) males may be infertile.[59] 5) Margo found an increased hyperactivity in males compared to females.[60] Above all the special needs of the male should be respected. It is unhelpful and demeaning to treat males as if they were teenage girls.[61]

Sexual Orientation and Body Image as Etiology of Eating Disorders

"The issue of sexual orientation in males with eating disorders is one area that remains controversial. Earlier reports had suggested there was incidence of homosexuality in males with eating disorders.[62] One reason for this association of sexual orientation and males with eating disorders has been the prevalence of "superfeminine" scores on the "masculinity-femininity" scale of the Freiburger

Personality Inventory in studies conducted by Herzog, Bradburn and Newan.[63] Further studies in this area by Woodside, Garner, Rockert and Garfinkel have produced similar results.[64] Crisp and Burns state that "either at a active or fantasy level, roughly a quarter of the males with eating disorders describe doubt about their masculinity and some had been actively homosexual prior to their illness.[65]

The literature states that homosexual males are at greater risk for developing eating disorders due to the pressures of sociocultural expectations to be thin. While heterosexual males tend to have premorbid involvement with attitudes and well developed physiques.[66] These findings lead the issue of males' perception of their body image. The concept that males are concerned with physical fitness and their outwardly physical appearance is still being portrayed by today's media. Magazines geared toward males are centered around fitness, weight lifting, body building or muscle toning.[67] "Men's magazines emphasize activity, movement and physical prowess.[68] Other researchers have stated "that premorbid involvement in athletics has been fond to characterize male anorexics and perhaps some fully fledged male anorexics lurk undetected amongst the welter of male athletes."[69] In a study of males with eating disorders, male homosexuals were found to be more premorbidly obese than male heterosexuals and on the average weighted significantly more. Perhaps as with females who suffer from a eating disorder, the homosexual male feels increased pressure to slim down as their weight deviates from what is culturally valued, and this pressure contributes to the etiology of the eating disorder.[70]

Crisp has suggested that homosexual conflict in the male may play a comparable role to that of the heterosexual threat in females.[71] This is because homosexuals are thought to be very feminine in nature with no obvious masculine traits, other than their apparent physical traits. The homosexual male subculture places an elevated importance on all aspects of the males' physical self: body build, grooming, dress, and facial features. This aspect of their lives goes against the old nursery rhyme: "Little girls are made of sugar and spice and everything nice. Little boys are made of snipe and snails and puppy dog tails." It is hypothesized that this perceived ideal would increase the risk of disordered eating among homosexual males.[72] The heterosexual male's self-esteem appears to be more readily influenced by a gap between his perceived and ideal body.[73] Crisp, Dally, Tom & Scott all have noted that homosexual conflict preceded the onset of an eating disorder in up to 50% of males in their studies.[74] Other studies suggest that homosexual orientation is frequently but not necessarily associated with eating disorders in males. However, they may have hyperfeminine identification patterns and experience sex-role confusion, but rarely problems of sexual orientation.[75] It is apparent that sexual anxieties appear to be present with respect to heterosexual as well as homosexual behavior. In addition there are indications of childhood and adolescent cross-gender behavior.[76]

Body Image

We are in an era of transition. Masculine and feminine traits are no longer perceived as opposite ends of a single dimension, but rather as coexisting and sometimes overlapping qualities in the same individual.[77] Macoby, Baruch and Barnett found that perceiving oneself as having traditionally feminine traits is unrelated to self-esteem, while perceiving oneself as having traditionally masculine traits is associated with high self-esteem.[78] Therefore males with eating disorders have very low self-esteem.

Strength and prowess may be emphasized in boys and men with a major investment in the development of strong limbs and muscles.[79] Males are taught at an early age not to cry or to show their emotions. They should always put up a brave front. The development of body image is a process beginning with the earliest stages of development. This process is the foundation upon which self-awareness, individuality and sense of the ego are built.[80] The sense of ego that the American culture develops is called "macho". Body image may only be understood in the context of the developmental process of the personality.

The "ideal male body form has varied in a cyclical nature over the generations. A young, perfectly formed, athletic physique characterized the ideal male in Greece in the fourth century B.C. Physical perfection was inextricably bound with intellectual and spiritual attainment."[81] Greeks did not believe males were happy people if they had bodies that were imperfect or old. Silent film star Fatty Arbuckle is quoted as saying that "nobody loves a fat man."[82]

The quality of body image is a function of socialization experiences. These qualities begin to appear with the earliest experiences of the person in relation to a significant person in his family or home environment.[83] Depending on parents attitudes body image may be perceived as: good or bad, pleasing or displeasing, clean or dirty, loved or disliked.[84] Attitudes toward body image also come from comparisons with other bodies.[85] Persons with such security reliances upon family and friends are less able to adapt and are thus more susceptible to emotional disturbances.[86]

Schilder believes the image of the human body is that picture of our own body which we form in our minds as a tridimensional unity involving interpersonal, environmental, and temporal factors. He also related the body image concept to curiosity, expression of emotions, social relations, duty and even ethics.[87] The way males view their bodies is a complex construct of their entire lives. In his consideration the borderline between body image and the psychoanalytic concept of the ego is obscure. He specifically suggests that one go beyond the purely perceptive side of the body image development as constant and underlying throughout life, something which takes or views the body as an object toward which it has percepts, thoughts and feelings.[88] This suggests that the body should not be seen as an object but as a reflection of a person's inner being.

The ego relates to the body (of the self) as an object, with mutual interaction between the ego and the body as an object.[89] Head's definition of body image is perceptions, attitudes, emotions, and personality reactions of the individual in relation

to his own body.[90] The distortion of the customary body image is experienced as a distortion of the self.[91]

The literature that is available about males with eating disorders leaves so many questions unanswered. Normal-weight males who desire to be thin and see themselves as overweight, do they in fact constitute a population at risk for eating disorders?[92] The amplified emphasis on appearance appears to heighten the male's vulnerability to the behaviors and attitudes associated with disordered eating. The need for further study of these issues is indicated.[93]

The fact that fewer males are identified as anorexic makes it difficult to make generalizations about them. Much of the research done on male subjects, contend that if a cause can be determined for their development of eating disorders it would be a major break through for males and females alike. However, characteristics that are typical lead to passivity and emphasis on food control.[94] Male anorexics may hold important clues to our understanding of the nature of anorexia. What characterizes those males who become sensitive about their fatness and embark on caloric restrictions that burgeon to characterize the disorder?[95] An understanding of the sociocultural factors influencing body shape and size in males may help the social work profession understand not only why eating disorders are less frequent in males than females, but also why they occur in those males who do experience them and why eating disorders may be overrepresented in certain subgroups of the male population.[96]

Due to the fact that the prevalence of bulimia in the male population is predicted to increase, strategies for the for the prevention of bulimia must be developed. Unfortunately, such strategies include the modification of societal norms that have powerful influences on individuals.[97] This can possibly be done with the aid of information provided by studies on the body image concerns of normal and eating disordered males. Some studies have offered a preliminary risk factor model which needs further validation because of the correlational nature of the data.[98]

Several studies suggest that homosexuality is common in males with eating disorders. However, clinic samples may underrepresent heterosexual males, who may be more reluctant than homosexual males to seek help for what are popularly known as female disorders.[99] The possible homosexual factor is probably not some specific sexual inclination but rather a general lack of sexuality. It has not yet been established if there is a greater population of homosexuals within the male population than in the general population.[100] The literature on eating disorders points out the fact that sexual issues are important in the evaluation and treatment of males.[101] Thus, future studies should attempt to distinguish between sexual behavior and sexual identity in males.[102]

OVERVIEW OF MAJOR THEORETICAL ORIENTATIONS

Eating disorders are the result of a very complex set of symptoms, both biological and psychological. Researchers of these disorders have not developed a consistent and coherent method (model) for assessment and treatment of the disorders.

In an effort to accomplish this, familial, sociocultural, behavioral, and psychodynamic theorist have conceptualized models of eating disorders.

Familial Models

Familial factors are influential in either the etiology or the maintenance of eating disorders.[103] When assessing a person for eating disorder it is important to pay particular attention to triangles, subsystems and their boundaries, and differentiation within the family. A majority of the time eating disorders are developed because the individual is not allowed any differentiation to become autonomous. Developing an eating disorder is most often a coping mechanism the individual uses to establish some control over their life.[104]

Family patterns of communication suggest lack of problem solving skills, non-supportive of independent behavior and have higher achievement expectations.[105] It has been speculated that the family environment increases rather than decreases the risk of eating disorders.[106] Examine these perspectives and significant elements of the sociocultural view emerges.

Sociocultural Model

The literature is not clear concerning the sociocultural factors that cause eating disorders yet it is evident that symptoms are reinforced by the culture in which these lives are formed. Garner and Associates[107] suggests that one could speculate that the destabilization of gender role norms would be particularly unsettling for a group

who is already predisposed to affective instability. As a result this population reacts with maladaptive coping skills.

Behavioral Model

Men and women who have fallen victim to eating disorders are exhibiting learned maladaptive response patterns reinforced by society's socialization.[108] These are learned behaviors for dealing with stress and emotional problems. These negative feelings of deprivation, depression, anxiety, anger and relationship problems involving loss and rejection are reduced by binge eating and/or dietary restraint.[109]

Psychodynamic Model

"The most prominent psychosocial theoretical view suggest psychodynamic model[110] etiology of eating disorders. One of the assumptions of the psychodynamic model is that at the root of any defense is a conflict (eating disorder) which generates anxiety. Therefore, a defense is an adaptive or maladaptive maneuver a person undertakes to keep from being aware of something which causes anxiety. The most common type of defense is repression-- the unconscious attempt to keep anxiety from producing conflicts out of awareness. This model further attempts to maintain a balance between the triangulation of the "lid", "ego" and "superego" for a more adaptive functioning of the ego in conflict.[111] This theory is based on the belief that critical conflicts in early life contribute to later problems. Psychodynamic therapist describe the etiology as the arrest of transitional object development at its earliest

stage.[112] Bruch[113] adheres to the analytic model by emphasizing the internalized early familial crisis associated with the development of eating disorders. The psychodynamic model will provide the social work practitioner with an explanation of how personality development plays an integral part of eating disorders among males. This model will also give attention to the development of body image and sexual orientation as part of the personality.

DEFINITION OF TERMS

Anorexia Nervosa - characterized by refusal to maintain body weight over minimal normal weight for age and height; intense fear of gaining weight or becoming fat, even though underweight; and a distorted body image.[114]

Bulimia Nervosa - characterized by recurrent episodes of binge eating, lack of control over eating behavior during binges, self-induced vomiting, use of laxatives or diuretic, strict dieting, vigorous exercise to prevent weight gain and persistent overconcern with body shape and weight.[115]

Eating Disorder - characterized by gross disturbances in behavior, it includes anorexia nervosa, bulimia nervosa and obesity.[116]

Sexual Orientation - one's preference of a sexual partner whether heterosexual, homosexual or bisexual.

Body Image - one's perception of or how a person sees his/her body shape and weight.

Anorexic - a person who fits the DSM III R criteria for anorexia.

Bulimic - a person who fits the DSM III R criteria for bulimia.

CRITICAL QUESTIONS

There are several critical questions that need to be answered about the development of eating disorders among males. The answers to these questions will provide conclusive answers to the etiology of eating disorders and tentative answers to the treatment of them.

The questions that this research will seek to examine are: What is the nature of sexuality in males with eating disorders? and What are the psychological characteristics of males with eating disorders?

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CHAPTER THREE

METHODOLOGY

Research Design

This was an exploratory study whose purpose was to identify and examine the many factors, involved in the etiology of eating disorders among males. Some of the factors examined in this study included the male's perception of body image and their sexual orientation.

Sampling

The sampling technique used in this study was convenience sampling. Due to the nature of this technique, the ability to generalize the data to a larger population is limited. The subjects for this study were 38 males who have never been assessed for a eating disorder. The males came from the Metro Atlanta Area. The subjects were at least 18 years of age. Differences in age, race, and sexual orientation were not controlled due to the method of sampling.

Data Collection Procedures/Instrumentation

The instruments used in this study were the Eating Disorders Inventory II (EDI-2) and the Bem Sex-Role Inventory (BSRI). All questionnaires were anonymous as no names were requested.

The Eating Disorders Inventory II is a 91 item scale that measures eight behavioral and psychological traits common to anorexics and bulimics, they are: drive

for thinness, bulimia, body dissatisfaction, ineffectiveness, perfectionism, interpersonal distrust, introceptive awareness and maturity fears. The last 27 items (items 65-91) provide a score for three provisional subscales that have not yet been standardized. These scales are asceticism, impulse regulation, and social insecurity. The EDI-2 is recommended for use as a screening device or as a aid in typological research.[117] It can be used for outpatient administration and can be easily administered in twenty minutes.

Criterion-related validity studies performed by comparing EDI patient profiles with the judgement of clinicians. These studies conducted by Garner, Olmsted & Polivy, as well as those conducted by the author the EDI David Garner. Convergent and discriminant validity was determined for the subscale samples of anorexia nervosa patients on the EDI.[118]

Reliability information was based on 271 college women. The reliability coefficients for the anorexia nervosa group ranged from .83 to .93 (standardized Chronbach's alphas) and the reliability coefficients for the college students ranged from .72 to .92.[119]

The Bem Sex-Role Inventory is a self-administered scale that can be completed in fifteen minutes. it scores for femininity, masculinity and femininity minus masculinity differences.[120] The BSRI "admits the possibility of those whose personality embraces both feminine and masculine traits.[121] According to the Mental Measurements Yearbook a number of studies suggest that the BSRI femininity and/or masculinity scales are correlated with gender-related behaviors.

The concept of a person's sex role is a hypothetical construct, a concept that cannot objectively be shown actually to exist, but that is a convenient device for theoretical purposes of explanation and prediction. The BSRI represents an attempt to use a paper-and-pencil test to determine an individuals sex role. Therefore, considerations of the validity of the BSRI fall under the category of construct validity.[122] The construct validity is contingent on the quality and quantity of the studies that used the instrument and the convergence of the results and findings of each study.

Reliability of the BSRI is established through test-retest and internal consistency. Studies have shown that BSRI scores are consistent over time, thus supporting the idea that masculinity and femininity are independent of each other.[123]

Data Analysis

For the purpose of this study, the data were analyzed using descriptive statistics and were reported in terms of frequency and percentages. The SPSSX Configuration Vax System of Clark Atlanta University was utilized.

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CHAPTER FOUR

PRESENTATION OF RESULTS

The data collected in the study provided a profile of 38 subjects who participated in the two self administered questionnaires. The critical questions that were being addressed in the study were: What is the nature of sexuality in males with eating disorders? And what are the psychological characteristics of males with eating disorders?

Demographic data from the findings included information from 38 male subjects with a non-diagnosed eating disorder. Of the 38 participants, 1 (2.6 percent) was between the ages 18-20, 10 (26.3 percent) were in the age group 21-25, 9 (23.6 percent) were in the age group 26-30, 5 (13.1 percent) were in the age group 31-35, 7 (18.4 percent) were in the age group 36-40, 3 (7.8 percent) were in the age group 41-45, 1 (2.6 percent) was in the age group 46-50, 1 (2.6 percent) was in the age group 51-55, and 1 (2.6 percent) fell into the 56-60 age range.

Of the 38 respondents 25 (65.7 percent) were African-American, 11 (28.9 percent) were White, and 2 (5.2 percent) were in the category Other.

For the demographic of sexual orientation, 29 (76.3 percent) were heterosexual, 8 (21 percent) were homosexual, and 1 (2.6 percent) was bisexual.

In the area of education, 1 (2.6 percent) had less than a high school education, 1 (2.6 percent) completed high school, 19 (50 percent) had some college, 10 (26.3 percent) were college graduates, and 7 (18.4 percent) had post graduate degrees.

For the demographics of marital status, 14 (36.8 percent) were married/living together, 5 (13.1 percent) were divorced and 19 (50 percent) had never been married.

Income level data reflected 3 (7.8 percent) respondents total family income was under $10,000, 10 (26.3 percent) $10,000-20,000, 10 (26.3 percent) $20,000-30,000, 5 (13.1 percent) $30,000-40,000, 4 (10.5 percent) $40,000-50,000 and 6 (15.7 percent) with income ranging $50,000 and over.

For the demographic of weight, the respondents stated their present weights ranged from 115-255 pounds. Their ideal weights ranged from 125-225 pounds. Tables 1-8 summarizes the demographic data.

Table 1

Item 1: Age

	Frequency	Percentage
18 - 20	1	2.6
21 - 25	10	26.3
26 - 30	9	23.6
31 - 35	5	13.1
36 - 40	7	18.4
41 - 45	3	7.8
46 - 50	1	2.6
51 - 55	1	2.6
56 - 60	1	2.6
Total	38	100

Table 2

Item 2: Race

	Frequency	Percentage
African American	25	65.7
White	11	28.9
Hispanic	0	0
Asian	0	0
Other	2	5.2
Total	38	100

Table 3

Item 3: Sexual Orientation

	Frequency	Percentage
Heterosexual	29	76.3
Homosexual	8	21.0
Bisexual	1	2.6
Total	38	100

Table 4

Item 4: Marital Status

	Frequency	Percentage
Married/Partners	14	36.8
Separated	0	0
Widowed	0	0
Divorced	5	13.1
Never been married	19	50.0
Total	38	100

Table 5

Item 5: Education

	Frequency	Percentage
Less High School	1	2.6
High School Grad.	1	2.6
Some College	19	50.0
College Graduate	10	26.3
Post Graduate	7	18.4
Total	38	100

Table 6

Item 6: Total Family Income

	Frequency	Percentage
Under $10,000	3	7.8
$10,000 - $20,000	10	26.3
$20,000 - $30,000	10	26.3
$30,000 - $40,000	5	13.1
$40,000 - $50,000	4	10.5
Over $50,000	6	15.7
Total	38	100

Table 7

Item 7: What is your present weight?

	Frequency	Percentage
115	1	2.6
138	1	2.6
139	1	2.6
140	1	2.6
150	2	5.2
154	1	2.6
155	1	2.6
160	1	2.6
170	2	5.2
175	6	15.7
180	3	7.8
185	4	10.5
190	2	5.2
195	1	2.6
198	1	2.6
208	1	2.6
210	1	2.6
220	2	5.2
223	1	2.6
225	1	2.6
232	1	2.6
235	1	2.6
240	1	2.6
255	1	2.6
Total	38	100

Table 8

Item 8: What do you consider you idea weight?

	Frequency	Percentage
125	1	2.6
130	1	2.6
140	1	2.6
145	1	2.6
147	1	2.6
150	2	5.2
155	2	5.2
156	2	2.6
160	4	5.2
165	3	10.5
170	1	7.8
175	1	2.6
180	4	10.5
185	3	7.8
189	2	5.2
190	5	13.1
200	2	5.2
210	1	2.6
225	1	2.6
Total	38	100

Tables 10,13,16,19,22,25,28,31,34,37,40,43,46,49,52,55,58,61,64 and 67 all represent feminine character traits. Tables, 9, 12, 15, 18, 21, 24, 27, 30, 33, 36,39, 42, 45, 48, 51, 54, 57, 60, 63, and 66 all represent masculine character traits. The data that was summarized on each table indicates that these male respondents have incorporated feminine and masculine character traits into their personalities.

Table 10

Item 10: Affectionate

	Frequency	Percentage
Never true	0	0
Usually not true	0	0
Occassionally true	6	15.7
Sometimes true	4	10.5
Often true	5	13.1
Usually true	13	34.2
Always true	10	26.3
Total	38	100

Table 13

Item 13: Sympathetic

	Frequency	Percentage
Never true	0	0
Usually not true	1	2.6
Occassionally true	3	7.8
Sometimes true	1	2.6
Often true	10	26.3
Usually true	13	34.2
Always true	10	26.3
Total	38	100

Table 16

Item 16: Sensitive to needs of others

	Frequency	Percentage
Never true	0	0
Usually not true	0	0
Occassionally true	4	10.5
Sometimes true	3	7.8
Often true	3	7.8
Usually true	19	50.0
Always true	9	23.6
Total	38	100

Table 19

Item 19: Understanding

	Frequency	Percentage
Never true	0	0
Usually not true	0	0
Occassionally true	1	2.6
Sometimes true	1	2.6
Often true	8	21.0
Usually true	11	28.9
Always true	17	44.7
Total	38	100

Table 22

Item 22: Compassionate

	Frequency	Percentage
Never true	0	0
Usually not true	1	2.6
Occassionally true	3	7.8
Sometimes true	1	2.6
Often true	6	15.7
Usually true	15	39.4
Always true	12	31.4
Total	38	100

Table 25

Item 25: Eager to soothe hurt feelings

	Frequency	Percentage
Never true	1	2.6
Usually not true	1	2.6
Occassionally true	7	18.4
Sometimes true	5	13.1
Often true	3	7.8
Usually true	9	23.6
Always true	12	31.5
Total	38	100

Table 28

Item 28: Warm

	Frequency	Percentage
Never true	2	5.2
Usually not true	0	0
Occassionally true	3	7.8
Sometimes true	0	0
Often true	10	26.3
Usually true	13	34.2
Always true	10	26.3
Total	38	100

Table 31

Item 31: Tender

	Frequency	Percentage
Never true	3	7.8
Usually not true	0	0
Occassionally true	6	15.7
Sometimes true	3	7.8
Often true	7	18.4
Usually true	11	28.9
Always true	8	21.0
Total	38	100

Table 34

Item 34: Love children

	Frequency	Percentage
Never true	0	0
Usually not true	1	2.6
Occassionally true	1	2.6
Sometimes true	2	5.2
Often true	5	13.1
Usually true	11	28.9
Always true	18	47.3
Total	38	100

Table 37

Item 37: Gentle

	Frequency	Percentage
Never true	0	0
Usually not true	0	0
Occassionally true	2	0
Sometimes true	3	5.2
Often true	9	7.8
Usually true	14	23.6
Always true	10	36.8
Total	38	100

Table 40

Item 40: Yielding

	Frequency	Percentage
Never true	2	5.2
Usually not true	3	7.8
Occassionally true	14	36.8
Sometimes true	7	18.4
Often true	6	15.7
Usually true	3	7.8
Always true	3	7.8
Total	38	100

Table 43

Item 43: Cheerful

	Frequency	Percentage
Never true	0	0
Usually not true	0	0
Occassionally true	6	15.7
Sometimes true	2	5.2
Often true	10	26.3
Usually true	10	26.3
Always true	10	26.3
Total	38	100

Table 46

Item 46: Shy

	Frequency	Percentage
Never true	6	15.7
Usually not true	9	23.6
Occassionally true	8	18.4
Sometimes true	7	21.0
Often true	2	5.2
Usually true	4	10.5
Always true	2	5.2
Total	38	100

Table 49

Item 49: Flatterable

	Frequency	Percentage
Never true	2	5.2
Usually not true	2	5.2
Occassionally true	9	23.6
Sometimes true	3	7.8
Often true	7	18.4
Usually true	11	28.9
Always true	4	10.5
Total	38	100

Table 52

Item 52: Loyal

	Frequency	Percentage
Never true	0	0
Usually not true	0	0
Occassionally true	1	2.6
Sometimes true	1	2.6
Often true	6	15.7
Usually true	9	23.6
Always true	21	55.2
Total	38	100

Table 55

Item 55: Soft-spoken

	Frequency	Percentage
Never true	5	13.1
Usually not true	6	15.7
Occassionally true	4	10.5
Sometimes true	5	13.1
Often true	6	15.7
Usually true	7	18.4
Always true	5	13.1
Total	38	100

Table 58

Item 58: Gullible

	Frequency	Percentage
Never true	9	23.6
Usually not true	12	31.5
Occassionally true	3	7.8
Sometimes true	7	18.4
Often true	4	10.5
Usually true	3	7.8
Always true	0	0
Total	38	100

Table 61

Item 61: Childlike

	Frequency	Percentage
Never true	8	21.0
Usually not true	6	15.7
Occassionally true	5	13.1
Sometimes true	10	26.3
Often true	4	10.5
Usually true	5	13.1
Always true	0	0
Total	38	100

Table 64

Item 64: Do not use harsh language

	Frequency	Percentage
Never true	3	7.8
Usually not true	7	18.4
Occassionally true	6	15.7
Sometimes true	4	10.5
Often true	6	15.7
Usually true	4	10.5
Always true	8	21.0
Total	38	100

Table 67

Item 67: Feminine

	Frequency	Percentage
Never true	21	55.2
Usually not true	6	15.7
Occassionally true	3	7.8
Sometimes true	7	18.4
Often true	1	2.6
Usually true	0	0
Always true	0	0
Total	38	100

Table 9

Item 9: Defend my own beliefs

	Frequency	Percentage
Never true	1	2.6
Usually not true	1	2.6
Occassionally true	0	0
Sometimes true	1	2.6
Often true	4	10.5
Usually true	10	26.3
Always true	21	55.2
Total	38	100

Table 12

Item 12: Independent

	Frequency	Percentage
Never true	0	0
Usually not true	1	2.6
Occassionally true	0	0
Sometimes true	1	2.6
Often true	7	18.4
Usually true	11	28.9
Always true	18	47.3
Total	38	100

Table 15

Item 15: Assertive

	Frequency	Percentage
Never true	0	0
Usually not true	1	2.6
Occassionally true	4	10.5
Sometimes true	4	10.5
Often true	8	21.0
Usually true	11	28.9
Always true	10	26.3
Total	38	100

Table 18

Item 18: Strong Personality

	Frequency	Percentage
Never true	0	0
Usually not true	2	5.2
Occassionally true	1	2.6
Sometimes true	1	2.6
Often true	4	10.5
Usually true	15	39.4
Always true	15	39.4
Total	38	100

Table 21

Item 21: Forceful

	Frequency	Percentage
Never true	4	10.5
Usually not true	10	26.3
Occassionally true	10	26.3
Sometimes true	6	15.7
Often true	3	7.8
Usually true	3	7.8
Always true	2	5.2
Total	38	100

Table 24

Item 24: Have leadership abilities

	Frequency	Percentage
Never true	0	0
Usually not true	0	0
Occassionally true	0	0
Sometimes true	2	5.2
Often true	6	15.7
Usually true	15	39.4
Always true	15	39.4
Total	38	100

Table 27

Item 27: Willing to take risks

	Frequency	Percentage
Never true	1	2.6
Usually not true	4	10.5
Occassionally true	5	13.1
Sometimes true	8	21.0
Often true	2	5.2
Usually true	11	28.9
Always true	7	18.4
Total	38	100

Table 30

Item 30: Dominant

	Frequency	Percentage
Never true	3	7.8
Usually not true	4	10.5
Occassionally true	6	15.7
Sometimes true	8	21.0
Often true	3	7.8
Usually true	10	26.3
Always true	4	10.5
Total	38	100

Table 33

Item 33: Willing to take a stand

	Frequency	Percentage
Never true	0	0
Usually not true	0	0
Occassionally true	0	0
Sometimes true	5	13.1
Often true	8	21.0
Usually true	12	31.5
Always true	13	34.2
Total	38	100

Table 36

Item 36: Aggressive

	Frequency	Percentage
Never true	2	5.2
Usually not true	7	18.4
Occassionally true	4	10.5
Sometimes true	7	18.4
Often true	3	7.8
Usually true	7	18.4
Always true	8	21.0
Total	38	100

Table 39

Item 39: Self-reliant

	Frequency	Percentage
Never true	1	2.6
Usually not true	0	0
Occassionally true	2	5.2
Sometimes true	4	10.5
Often true	4	10.5
Usually true	20	52.6
Always true	7	18.4
Total	38	100

Table 42

Item 42: Athletic

	Frequency	Percentage
Never true	0	0
Usually not true	4	10.5
Occassionally true	6	15.7
Sometimes true	7	18.4
Often true	9	23.6
Usually true	7	18.4
Always true	5	13.1
Total	38	100

Table 45

Item 45: Analytical

	Frequency	Percentage
Never true	0	0
Usually not true	4	10.5
Occassionally true	6	15.7
Sometimes true	6	15.7
Often true	3	7.8
Usually true	10	26.3
Always true	9	23.6
Total	38	100

Table 48

Item 48: Make decisions easily

	Frequency	Percentage
Never true	1	2.6
Usually not true	1	5.2.6
Occassionally true	5	13.1
Sometimes true	4	10.5
Often true	11	28.9
Usually true	12	31.5
Always true	4	10.5
Total	38	100

Table 51

Item 51: Self-Sufficient

	Frequency	Percentage
Never true	0	0
Usually not true	2	5.2
Occassionally true	2	5.2
Sometimes true	4	10.5
Often true	8	21.0
Usually true	13	34.2
Always true	9	23.6
Total	38	100

Table 54

Item 54: Individualistic

	Frequency	Percentage
Never true	0	0
Usually not true	1	2.6
Occassionally true	3	7.8
Sometimes true	4	10.5
Often true	5	13.1
Usually true	15	39.4
Always true	10	26.3
Total	38	100

Table 57

Item 57: Masculine

	Frequency	Percentage
Never true	0	0
Usually not true	0	0
Occassionally true	1	2.6
Sometimes true	1	2.6
Often true	5	13.1
Usually true	15	39.4
Always true	16	42.1
Total	38	100

Table 60

Item 60: Competitive

	Frequency	Percentage
Never true	0	0
Usually not true	4	10.5
Occassionally true	5	13.1
Sometimes true	8	21.0
Often true	6	15.7
Usually true	10	26.3
Always true	5	13.1
Total	38	100

Table 63

Item 63: Ambitious

	Frequency	Percentage
Never true	0	0
Usually not true	0	0
Occassionally true	0	0
Sometimes true	5	13.1
Often true	5	13.1
Usually true	15	39.4
Always true	13	34.2
Total	38	100

Table 66

Item 66: Act as a leader

	Frequency	Percentage
Never true	0	0
Usually not true	0	0
Occassionally true	2	5.2
Sometimes true	4	10.5
Often true	9	23.6
Usually true	12	31.5
Always true	11	28.9
Total	38	100

The following tables show variables that are indicative for traits among males and females who are anorexic and/or bulimic. These traits are with regard to a drive for thinness, binge eating (bulimia), and body dissatisfaction. The data indicates that a small percentage of the respondents exhibit behaviors that are indicators for developing an eating disorder.

DRIVE FOR THINNESS

Table 69

Item 69: I eat sweets and carbohydrates without feeling nervous

	Frequency	Percentage
Always	10	26.3
Usually	7	18.4
Often	7	18.4
Sometimes	5	13.1
Rarely	3	7.8
Never	6	15.7
Total	38	100

Table 75

Item 75: I think about dieting

	Frequency	Percentage
Always	4	10.5
Usually	3	7.8
Often	4	10.5
Sometimes	11	28.9
Rarely	2	5.2
Never	14	36.8
Total	38	100

Table 79

Item 79: I feel extremely guilty after overeating

	Frequency	Percentage
Always	0	0
Usually	2	5.2
Often	3	7.8
Sometimes	3	7.8
Rarely	10	26.3
Never	20	52.6
Total	38	100

Table 84

Item 84: I am terrified of gaining weight

	Frequency	Percentage
Always	2	5.2
Usually	2	5.2
Often	2	5.2
Sometimes	10	26.3
Rarely	9	23.6
Never	13	34.2
Total	38	100

Table 93

Item 93: I exaggerate or magnify the importance of weight

	Frequency	Percentage
Always	1	2.6
Usually	0	0
Often	4	10.5
Sometimes	8	21.0
Rarely	8	21.0
Never	17	44.7
Total	38	100

Table 100

Item 100: I am preoccupied with the desire to be thinner

	Frequency	Percentage
Always	0	0
Usually	3	7.8
Often	3	7.8
Sometimes	8	21.0
Rarely	9	23.6
Never	15	39.4
Total	38	100

Table 117

Item 117: If I gain a pound, I worry that I will keep gaining

	Frequency	Percentage
Always	2	5.2
Usually	2	5.2
Often	2	5.2
Sometimes	3	7.8
Rarely	12	31.5
Never	17	44.7
Total	38	100

Table 71

Item 71: I wish that I could return to the security of childhood

	Frequency	Percentage
Always	1	2.6
Usually	2	5.2
Often	3	7.8
Sometimes	9	23.6
Rarely	10	26.3
Never	13	34.2
Total	38	100

Table 72

Item 72: I eat when I am upset

	Frequency	Percentage
Always	0	0
Usually	3	7.8
Often	3	7.8
Sometimes	6	15.7
Rarely	10	26.3
Never	16	42.1
Total	38	100

Table 96

Item 96: I have gone on eating binges where I felt that I could not stop

	Frequency	Percentage
Always	0	0
Usually	0	0
Often	0	0
Sometimes	4	10.5
Rarely	7	18.4
Never	27	71.0
Total	38	100

Table 106

Item 106: I think about binging (overeating)

	Frequency	Percentage
Always	1	2.6
Usually	0	0
Often	3	7.8
Sometimes	2	5.2
Rarely	7	18.4
Never	25	65.7
Total	38	100

Table 114

Item 114: I eat moderately in front of others and stuff myself when they are gone

	Frequency	Percentage
Always	1	2.6
Usually	0	0
Often	0	0
Sometimes	5	13.1
Rarely	3	7.8
Never	29	76.3
Total	38	100

Table 129

Item 129: I eat or drink in secrecy

	Frequency	Percentage
Always	0	0
Usually	0	0
Often	2	5.2
Sometimes	4	10.5
Rarely	3	7.8
Never	29	76.3
Total	38	100

Table 121

Item 121: I have the thought of trying to vomit in order to lose weight

	Frequency	Percentage
Always	0	0
Usually	1	2.6
Often	0	0
Sometimes	0	0
Rarely	1	2.6
Never	36	94.7
Total	38	100

Table 70

Item 70: I think that my stomach is too big.

	Frequency	Percentage
Always	10	26.3
Usually	2	5.2
Often	4	10.5
Sometimes	8	21.0
Rarely	4	10.5
Never	10	26.3
Total	38	100

Table 77

Item 77: I think that my thighs are too large

	Frequency	Percentage
Always	1	2.6
Usually	0	0
Often	1	2.6
Sometimes	3	7.8
Rarely	6	15.7
Never	27	71.0
Total	38	100

Table 80

Item 80: I think that my stomach is just the right size

	Frequency	Percentage
Always	8	21.0
Usually	7	18.4
Often	2	5.2
Sometimes	1	2.6
Rarely	8	21.0
Never	12	31.5
Total	38	100

Table 87

Item 87: I feel satisfied with the shape of my body

	Frequency	Percentage
Always	5	13.1
Usually	6	15.7
Often	6	15.7
Sometimes	8	21.0
Rarely	9	23.6
Never	4	10.5
Total	38	100

Table 99

Item 99: I like the shape of my buttocks

	Frequency	Percentage
Always	14	36.8
Usually	11	28.9
Often	4	10.5
Sometimes	5	13.1
Rarely	2	5.2
Never	2	5.2
Total	38	100

Table 113

Item 113: I think my hips are too big

	Frequency	Percentage
Always	2	5.2
Usually	1	2.6
Often	0	0
Sometimes	2	5.2
Rarely	7	18.4
Never	26	68.4
Total	38	100

Table 123

Item 123: I think that my thighs are just the right size

	Frequency	Percentage
Always	12	31.5
Usually	9	23.6
Often	3	7.8
Sometimes	5	13.1
Rarely	6	15.7
Never	3	7.8
Total	38	100

Table 127

Item 127: I think my buttocks are too large

	Frequency	Percentage
Always	1	2.6
Usually	0	0
Often	1	2.6
Sometimes	1	2.6
Rarely	8	21.0
Never	27	71.0
Total	38	100

Table 130

Item 130: I think that my hips are just the right size

	Frequency	Percentage
Always	15	39.4
Usually	8	21.0
Often	3	7.8
Sometimes	4	10.5
Rarely	5	13.1
Never	3	7.8
Total	38	100

CHAPTER FIVE

SUMMARY AND CONCLUSIONS

One of the reasons for this research was a concern about eating disorders among males. It has been suggested that if a cause can be determined for male eating disorders it would be a major breakthrough for both males and females with eating disorders. The probability of discovering the etiological factors of male eating disorders has many multifaceted levels to explore.

Arnold Andersen has suggested several critical questions based on the current literature for answers to the etiology of male eating disorders. 1) Do males develop eating disorders?; 2) How many males suffer from an eating disorder?; 3) Why do so few males develop eating disorders?; 4) Why do certain males develop eating disorders?; 5) Are there differences in the natural history of males and females in the development of eating disorders?; 6) What is the nature of sexuality in males with eating disorders?; 7) What are the psychological characteristics of males with eating disorders?; and 8) Treatment of males with eating disorders: How are they similar, How are they different? This study briefly touched upon some of these questions and addressed two of them.

Consequently, in regards to this study, it is fair to say that males are at risk for developing eating disorders. Key indicators would be dieting patterns and body dissatisfaction. There was no significant differences found between the responses of

heterosexual and homosexual males. However, many other factors are missing from this study.

LIMITATIONS OF THE STUDY

The limitation of this study is that it focused on a small convenient group. The participants were only those males who were employed in a psychiatric setting; the condition in which the test was administered was actually at the convenience of each individual participant. No generalizations about these findings can be made beyond this particular sample population.

SUGGESTED RESEARCH DIRECTIONS

Further studies need to identify the nature of the causal relationship between dieting patterns and sexual orientation. There are areas in which more research needs to be done. One area is an investigation into how male personality development of masculine and feminine traits affects their body image concept as it is dictated by their culture. Another aspect that should be investigated is the difference between sexual behavior and sexual identity in males.

CHAPTER SIX

IMPLICATIONS FOR SOCIAL WORK PRACTICE

The occurrence of eating disorders is increasing among the male population. Due to the prevalence among females and now males, a better understanding is needed by the social work profession. The social work profession should seek to educate itself, other professions, and most importantly the public about these disorders. Education is the best form of prevention.

The problems of these emotional based disorders are not linear but multifaceted in etiology. It is the obligation of the social work profession to become more knowledgeable about the many etiological factors and to understand how they affect the environment of males with eating disorders.

To effectively deal with an individual (male) who has an eating disorder, the social work profession needs to use the person-in-environment perspective/approach. The eating disordered male is a person who interacts in many different systems which could have caused or maintained the disorder. The efforts of the social work profession is to develop an intervention from a biopsychosocial model.

APPENDICES

Dear Student,

I am enrolled in a Master's Degree Program at Clark Atlanta University School of Social Work. Currently, I am completing a study on the eating patterns of adult males. The enclosed questionnaires were designed to obtain knowledge about maladaptive eating patterns and particular character traits. Please assist me by completing the attached questionnaires. Your participation is strictly voluntary.

You will find some questions to be quite personal in nature and you might feel uncomfortable or embarrassed about answering some of the questions. Be assured that your answers will be completely anonymous. I would like for you to answer each item as carefully and accurately as possible.

It is my hope that this research will contribute to an understanding of maladaptive eating patterns that may lead to the development of eating disorders. Your time and care in completing these questionnaires is greatly appreciated. If you would like to find out about the results of this study or have any concerns regarding the questionnaire, please contact me through the Clark Atlanta University School of Social Work (404) 880-8550.

Thank you for participating in this important study.

Sincerely,

Maestro A. Evans
Researcher

Professor Hattie Mitchell
Thesis Advisor

Enclosure

DEMOGRAPHIC CHARACTERISTICS

AGE_____
RACE_____

SEXUAL ORIENTATION

_____ Heterosexual
_____ Homosexual
_____ Bisexual

MARITAL STATUS

_____ Married/Living Together
_____ Separated
_____ Widowed
_____ Divorced
_____ Never Been Married

EDUCATION

_____ Less than High School
_____ High School Graduate
_____ At Least Some College
_____ College Graduate
_____ Post Graduate

TOTAL FAMILY INCOME

_____ Under $10,000
_____ $10,000 - $20,000
_____ $20,000 - $30,000
_____ $30,000 - $40,000
_____ $40,000 - $50,000
_____ Over $50,000

What is your present weight?_____

What do you consider your ideal weight?_____

MIND GARDEN
Palo Alto California

Original Form

1 Never or almost never true **2** Usually not true **3** Sometimes but infrequently true **4** Occasionally true
5 Often true **6** Usually true **7** Always or almost always true

1. Defend my own beliefs		31. Self-reliant	
2. Affectionate		32. Yielding	
3. Conscientious		33. Helpful	
4. Independent		34. Athletic	
5. Sympathetic		35. Cheerful	
6. Moody		36. Unsystematic	
7. Assertive		37. Analytical	
8. Sensitive to needs of others		38. Shy	
9. Reliable		39. Inefficient	
10. Strong personality		40. Make decisions easily	
11. Understanding		41. Flatterable	
12. Jealous		42. Theatrical	
13. Forceful		43. Self-sufficient	
14. Compassionate		44. Loyal	
15. Truthful		45. Happy	
16. Have leadership abilities		46. Individualistic	
17. Eager to soothe hurt feelings		47. Soft-spoken	
18. Secretive		48. Unpredictable	
19. Willing to take risks		49. Masculine	
20. Warm		50. Gullible	
21. Adaptable		51. Solemn	
22. Dominant		52. Competitive	
23. Tender		53. Childlike	
24. Conceited		54. Likable	
25. Willing to take a stand		55. Ambitious	
26. Love children		56. Do not use harsh language	
27. Tactful		57. Sincere	
28. Aggressive		58. Act as a leader	
29. Gentle		59. Feminine	
30. Conventional		60. Friendly	

INSTRUCTIONS

First, write your name and the date on your EDI-2 Answer Sheet. Your ratings on the items below will be made on the EDI-2 Answer Sheet. The items ask about your attitudes, feelings, and behavior. Some of the items relate to food or eating. Other items ask about your feelings about yourself.

For each item, decide if the item is true about you ALWAYS (A), USUALLY (U), OFTEN (O), SOMETIMES (S), RARELY (R), or NEVER (N). Circle the letter that corresponds to your rating on the EDI-2 Answer Sheet. For example, if your rating for an item is OFTEN, you would circle the O for that item on the Answer Sheet.

Respond to all of the items, making sure that you circle the letter for the rating that is true about you. DO NOT ERASE! If you need to change an answer, make an "X" through the incorrect letter and then circle the correct one.

---

1. I eat sweets and carbohydrates without feeling nervous.
2. I think that my stomach is too big.
3. I wish that I could return to the security of childhood.
4. I eat when I am upset.
5. I stuff myself with food.
6. I wish that I could be younger.
7. I think about dieting.
8. I get frightened when my feelings are too strong.
9. I think that my thighs are too large.
10. I feel ineffective as a person.
11. I feel extremely guilty after overeating.
12. I think that my stomach is just the right size.
13. Only outstanding performance is good enough in my family.
14. The happiest time in life is when you are a child.
15. I am open about my feelings.
16. I am terrified of gaining weight.
17. I trust others.
18. I feel alone in the world.
19. I feel satisfied with the shape of my body.
20. I feel generally in control of things in my life.
21. I get confused about what emotion I am feeling.
22. I would rather be an adult than a child.
23. I can communicate with others easily.
24. I wish I were someone else.
25. I exaggerate or magnify the importance of weight.
26. I can clearly identify what emotion I am feeling.
27. I feel inadequate.
28. I have gone on eating binges where I felt that I could not stop.
29. As a child, I tried very hard to avoid disappointing my parents and teachers.
30. I have close relationships.
31. I like the shape of my buttocks.
32. I am preoccupied with the desire to be thinner.
33. I don't know what's going on inside me.
34. I have trouble expressing my emotions to others.
35. The demands of adulthood are too great.
36. I hate being less than best at things.
37. I feel secure about myself.

38. I think about bingeing (overeating)
39. I feel happy that I am not a child anymore
40. I get confused as to whether or not I am hungry.
41. I have a low opinion of myself.
42. I feel that I can achieve my standards
43. My parents have expected excellence of me
44. I worry that my feelings will get out of control.
45. I think my hips are too big.
46. I eat moderately in front of others and stuff myself when they're gone.
47. I feel bloated after eating a normal meal.
48. I feel that people are happiest when they are children.
49. If I gain a pound, I worry that I will keep gaining.
50. I feel that I am a worthwhile person.
51. When I am upset, I don't know if I am sad, frightened, or angry.
52. I feel that I must do things perfectly or not do them at all
53. I have the thought of trying to vomit in order to lose weight.
54. I need to keep people at a certain distance (feel uncomfortable if someone tries to get too close)
55. I think that my thighs are just the right size.
56. I feel empty inside (emotionally).
57. I can talk about personal thoughts or feelings.
58. The best years of your life are when you become an adult.
59. I think my buttocks are too large.
60. I have feelings I can't quite identify.
61. I eat or drink in secrecy.
62. I think that my hips are just the right size.
63. I have extremely high goals.
64. When I am upset, I worry that I will start eating.
65. People I really like end up disappointing me.
66. I am ashamed of my human weaknesses.
67. Other people would say that I am emotionally unstable.
68. I would like to be in total control of my bodily urges.
69. I feel relaxed in most group situations.
70. I say things impulsively that I regret having said.
71. I go out of my way to experience pleasure.
72. I have to be careful of my tendency to abuse drugs.
73. I am outgoing with most people.
74. I feel trapped in relationships.
75. Self-denial makes me feel stronger spiritually.
76. People understand my real problems.
77. I can't get strange thoughts out of my head.
78. Eating for pleasure is a sign of moral weakness.
79. I am prone to outbursts of anger or rage.
80. I feel that people give me the credit I deserve.
81. I have to be careful of my tendency to abuse alcohol.
82. I believe that relaxing is simply a waste of time.
83. Others would say that I get irritated easily.
84. I feel like I am losing out everywhere.

(Continued)

85 I experience marked mood shifts.
86 I am embarrassed by my bodily urges
87 I would rather spend time by myself than with others
88 Suffering makes you a better person.
89 I know that people love me.
90 I feel like I must hurt myself or others
91 I feel that I really know who I am.

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PAR Psychological Assessment Resources, Inc.
P.O. Box 998/Odessa, Florida 33556/Toll-Free 1-800-331-TEST

Table 82

Item 82: The happiest time in life is when you are a child

	Frequency	Percentage
Always	2	5.2
Usually	2	5.2
Often	5	13.1
Sometimes	13	34.2
Rarely	8	21.0
Never	8	21.0
Total	38	100

Table 85

Item 85: I trust others

	Frequency	Percentage
Always	0	0
Usually	17	44.7
Often	5	13.1
Sometimes	13	34.2
Rarely	2	5.2
Never	1	2.6
Total	38	100

Table 86

Item 86: I feel alone in the world

	Frequency	Percentage
Always	0	0
Usually	1	2.6
Often	2	5.2
Sometimes	9	23.6
Rarely	11	28.9
Never	15	39.4
Total	38	100

Table 89

Item 89: I get confused about what emotion I am feeling

	Frequency	Percentage
Always	0	0
Usually	0	0
Often	3	7.8
Sometimes	13	34.2
Rarely	11	28.9
Never	11	28.9
Total	38	100

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